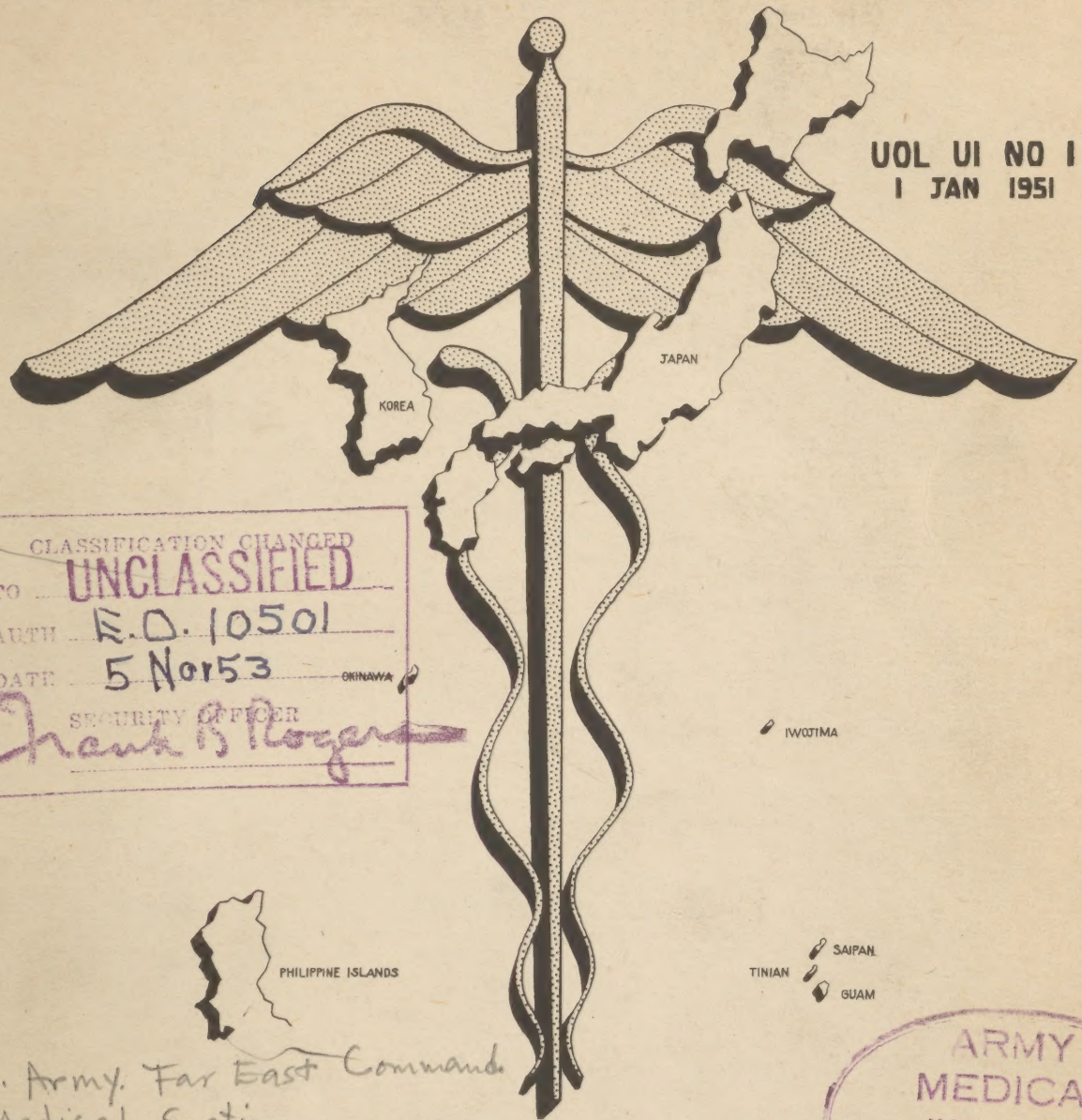


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SURGEON'S CIRCULAR LETTER

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ORGANIZATION OF THE MEDICAL SECTION, GHQ, FEC

The following is a list of commissioned personnel currently assigned or attached to the Medical Section:

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Col Richard H. Eckhardt, MC
Col Robert E. Selwyn, MSC

Chief Surgeon
Deputy Surgeon
Executive Officer

DENTAL SURGEON

Col Harold G. Ott, DC

ADMINISTRATIVE DIVISION

Capt John W. Barr, MSC
WOJG Ernie L. Barker

Chief
Ass't Chief

PLANS AND OPERATIONS DIVISION

Col William J. Moreland, MSC
Lt Col H. E. Archer, MSC
Maj Thomas P. Caito, MSC

Maj Vincent I. Hack, MSC
Maj Donald H. Behrens, MSC
Maj Eugene T. Brown, MSC

Chief
Chief, Opns Br
Ass't Chief,
Opns Br
Chief, Pub & Ed Br
Ass't Chief, Pub & Ed Br
Med Stat Officer

SUPPLY AND FISCAL DIVISION

Lt Col Everett W. Partin, MSC
Capt Richard M. Stacey, MSC

Chief
Ass't Chief

PERSONNEL DIVISION

Lt Col Charles Raulerson, MSC
Capt James F. Allen, MSC

Chief
Ass't Chief

CONSULTANTS DIVISION

Col Oral B. Bolibaugh, MC
Col Francis W. Pruitt, MC
Col Frank E. Hagman, MC
Col Albert J. Glass, MC
Col Arthur P. Long, MC
Col Arvo T. Thompson, VC
Lt Col S. J. Weidenkopf, MSC
Lt Col A. M. Gritsavage, ANC

Chief
Orthopedic Consultant
Medical Consultant
Surgical Consultant
Neuropsychiatric Consultant
Prev Med Consultant
Veterinary Consultant
Sanitary Engineer
Chief Nurse

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GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APD 500

NO. 1

1 January 1951

PART I

ADMINISTRATIVE

SUBJECT

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I. Army Nurse Awarded Bronze Star



Captain Margaret B. Blake, ANC, of New York City, was recently awarded the Bronze Star Medal for her outstanding services in Korea. The award was presented to Captain Blake by Maj. Gen. Edgar Erskine Hume, Chief Surgeon, FEC.

The citation read in part: "Under her direction and supervision, the wounded were given expedient care and treatment which saved many lives. The high quality of her work is shown by the favorable post-operative recovery by the patients. Her efficiency reflects great credit on herself and the Army Nurse Corps." The award covers the period 1 July to 1 October 1950.

Present at the ceremonies in Tokyo were nurses representative of the three services: Lt. Comdr. Alberta Burke, Navy Nurse Corps; Maj. Tosi, Air Force Nurse Corps; and Lt. Col. Mahoney, Army Nurse Corps.

II. Surgical Research Team - FEC

A surgical team comprised of two Army doctors has returned to the United States after completing intensive research into new methods of wound treatment in the Far East Command.

Lt. Colonel Edwin J. Pulaski, MC, and Major Curtis P. Artz, MC, of Brooke Army Medical College, Ft. Sam Houston, Texas, spent five weeks at the Tokyo Army Hospital conducting a study of thermal wound management and measure of antibiotic response to severe infection following battle injury. Eighty-four surgical procedures were performed during this period.

Subsequently, a week was spent on detached service with the 141st General Hospital, 118th Station Hospital and Osaka Army Hospital, to present a series of seminars, to acquaint professional staffs with test items and to allocate supplies of certain of these test items.

Technical data detailing the team's conclusions will be found in Part II, this issue.

III. Medical Officer's Professional Training Records

Attention is called to SR 40-10-45 which defines the use and emphasizes the importance of the Medical Officer's Professional Training Record. This record, maintained by the individual, and summarizing his military experiences, is presented by the officer to the various authorized accrediting boards for certification.

Although the form is furnished as a convenience to the active Medical Officer, it is his responsibility that the Training Record be maintained in a manner acceptable to his particular specialty board. The board usually grants credit toward board certification as a result of this record.

Copies of DD Form 408 may be procured by writing to the Medical Section, Personnel Division, GHQ, FEC, APO 500.

IV. New Course in Clinical Psychology



Beginning in early 1951, the Army Medical Service will offer enlisted personnel a 16-week course in elementary clinical psychology, to be presented at the Medical Field Service School, Brooke Army Medical Center, Ft. San Houston, Texas. Training will lead to the acquisition of MOS 289 - clinical psychology technician. Students will be trained to administer and score individual and group intelligence, literacy, and personality tests; interview patients and prepare reports of findings; assist patients to carry out psychologists' recommendations; and maintain records.

Those eligible for the course are enlisted men and women with high school diplomas, or the equivalent, who have qualified as neuropsychiatric technicians (MOS 1409) or personnel management technicians (MOS 290), and who have a score of 110, or higher, on aptitude area III.

V. Thailand Medical Teams Train for Air Evacuation

In preparation for the Military Air Transport Service return of the first of their Korean-wounded countrymen to Bangkok, Thailand medical personnel are now receiving instructions at Haneda Air Force Base, Japan, in current air evacuation techniques.

The first two teams, each consisting of two doctors and two nurses, have recently arrived from Bangkok's Army General Hospital.

Under the direction of MATS Air Force and Navy personnel, the Thailanders are learning how to stock air evacuation medical chests, use portable therapeutic oxygen tanks, give in-flight blood transfusions and other procedures.

VI. Interservice Transfer

DA Circulars 70 and 71 clarify the procedure by which commissioned officers of the Army Medical Service either on active or reserve status may apply for transfer to the Navy or Air Force.

Authority for the interdepartmental transfer which is contained in Public Law 779, 80th Congress, states a deadline of 9 July 1951. Applications containing information as defined in the Department of the Army Circulars will be forwarded through channels to The Adjutant General, Washington, 25, D. C.

VII. Truck Shuttle Speeds Medical Service



A front-line unit of the 2d Infantry Division in Korea has devised a "double-play" system to expedite the evacuation of casualties from a nearby clearing station.

Two and a half ton supply trucks, each capable of carrying 15 litter patients arranged in two layers across the truck bed, carry the wounded men to the rear. Re-

filled with provisions and ammunition, the vehicles return forward to unload and continue the evacuation procedure.

Doctors of the medical unit say the plan is proving "very successful".

VIII. Bus Ambulances

A problem in transportation from the receiving point to the receiving hospital was created in Japan with the receipt of large numbers of casualties at airfields and water ports. In July, the only types of ambulances available were the ordinary field ambulances and three 12-litter ambulances which had then arrived from the ZI. A type vehicle for hauling large numbers of patients was necessary in order to keep from tying up large convoys of the field ambulances. This problem was presented by the Medical Section to the Engineering Branch, Ordnance Section, Japan Logistical Command. In a move designed to provide a solution to this problem, plans for converting busses to ambulances were made by the Oppama Laboratory, Engineering Branch, Industrial Division, Ordnance Section,



JLCOM. The first model was built with sliding litter supports which were later replaced by canvas webbing straps at the suggestion of the Medical Section, JLCOM. After inspecting and approving the sample 10-litter ambulance, 50 busses were authorized for the first conversion project with 34 additional busses now in the process of being converted into ambulances, making a grand total of 84 ambulances.

The overall dimensions of the ambulances are as follows: they are 320" long, 94 1/2" wide, and 116" high. The vehicle weighs 12,900 pounds and possesses the same maneuverable characteristics as the 2 1/2 ton 6x6 cargo truck less the low speed gear range and front wheel drive. The ambulances are insulated with 1" of spun glass insulation and have right and left entrances in addition to emergency exit doors. Litters are carried through the rear door and seats are provided for attendants. Additional equipment consists of sirens, blinking red lights, turn indicators, rear entrance lights, etc. Mechanical chassis parts, engines, axles, etc., are interchangeable with standard Ordnance spare parts.

These vehicles, which are now in operation at all principal receiving points in Japan, have solved more than adequately the problem of mass transportation of casualties to receiving hospitals.

IX. Frostbite Classes

The third in a series of cold-weather indoctrination programs, begun in 1948, will be held early in 1951 at the Army Arctic Indoctrination Center, Big Delta, Alaska. The program will comprise two exercises, to be run in succession in January and February. Two groups of officer-student volunteers will participate in the exercises, which will stress techniques for individual survival in frigid climates. Scene of the exercises is in central Alaska on the banks of the Delta River, about 100 miles from Fairbanks.

X. Three Months in Korea with the 8055th Mobile Surgical Unit - Capt Phyllis M. LaConte, ANC, and Capt Mary E. Angelich, ANC



Florence Nightingale would be astonished and delighted if she could look down today upon the Army Nurse at work in the battlefields of Korea. For the pioneering spirit of the world's first "Angel of Mercy" has been perfected to such a high degree by the modern military nurse that it has left the realm of simple service to humanity. This spirit has become one of the very bulwarks in maintaining high rates of "returned to duty" entries on the lists of the wounded.

The role of the Army Nurse in the present conflict is graphically portrayed in a three months history of the 8055th Mobile Surgical Unit, which may be representative of the contributions made by all of the nurses in the service.

The 8055th, activated on 1 July, began its combat-zone duty in Taejon. It was withdrawn as far as Pusan, and then, as required by the changing military situation, returned to Taejon. In early September the unit found itself in Pusan, working in a school building near the heart of the city. There were long duty hours there for everyone, as trainloads of patients began to arrive from the front.

True to its name, the mobile unit was soon on the move again. The nurses remained behind for two days however to stay with the 8054th Evacuation Hospital, while the rest of their unit moved ahead to Taegu. There was just enough time to enjoy the comparative luxury of the 8054th Officers' Club where the nurses, clad in fatigues, and always "on call," danced to the music of an Army band. Before rejoining their unit at Taegu, the nurses' off-duty hours were spent in frantic spells of letter-writing and packing of field equipment. Because of the ever-present rush, rain-checks had to be taken for the many dinner and evening get-together invitations that had been extended. Only one invitation was accepted with unqualified enthusiasm: the alluring offer of the use of the 77th Artillery's mobile shower unit. Helmet baths had been adequate, but a warm shower was not to be refused.

After the plane trip forward, two ambulances and a 6x6 truck met the nurses at the Taegu airport to take them to the new installation which the male officers and enlisted men had already in operation. Soon everyone was in the swing of things again.

For many of the enlisted men, the work amounted to on-the-job training. They showed tremendous interest and made equally tremendous improvement in their work.

The cooperative spirit of everyone eased the pressure of constant arrivals of American and British personnel. An increasing number of casualties made it necessary to set up a receiving station where patients were first checked by a doctor and a nurse. Those in shock and those in need of immediate abdominal, chest or other major operations were sent to the "Pre-Op" Section and prepared for surgery.

Another innovation which helped to expedite the care of patients was the installation of an

orthopedic operating room to take care of necessary cast applications and other such treatments.

The "Post-Op" and holding sections were filled with casualties and everyone was striving to speed treatment sufficiently to permit evacuation of patients to Pusan or Japan. Work of the surgical teams continued around the clock each day.

Helicopters were frequently used in the chain of evacuation and the nurses stared in fascination as they found the backyard of the hospital had become a landing field for the huge "egg-beaters".

The 8055th followed the 24th Division as it advanced northward. The slow miles ahead were made in trucks, jeeps and ambulances, which crept cautiously over the dusty, narrow winding roads. Cameras which had been tucked away in musette bags were put to good use for everyone found much of interest along the way. Occasionally, contact was made with other hospitals which had arrived in the area. The nurses enjoyed seeing new faces, and hearing stateside news or word about the hospitals in Japan.

At Kumchon, the 8055th stopped for two days to care for the many badly injured Korean civilians. Many, in a primitive attempt at first aid, had covered their wounds or burns with green leaves or paper. Their gratitude for the professional treatment they received could not be expressed in words but it was evident in their smiles and the low bowing of their heads.

A school building which had been "air-conditioned" by artillery shells and air raids, served as a hospital during these two days. Cheery bonfires built in several parts of the compound took the sting away from the chilly evenings and provided a means of heating "C" rations.

At dawn, on 30 September, the unit started for the return move to Taejon, the city in which it first began to serve the combat troops. Hastily painted signs reading "On to Taejon" and "We have returned" were displayed on the ambulance convoy.

Enroute, at dawn, the unit made a 30-minute stop at Yongdong, where it had been in July. It was shocking to see that the agricultural college, which it had previously occupied, had been completely destroyed. No one could resist making an inspection trip of the area to look for landmarks of their earlier stay.

Members of the 24th Division had erected a "Welcome, 8055th Nurses" sign at the entrance to Taejon. And a royal welcome, complete with ROK flags and banners, was given the unit by Korean civilians.

Not one working hour had been lost because of illness among the nurses. Sniffles were checked almost immediately, and new fatigues, combat boots and field jackets that had been issued in Pusan helped to keep the nurses warm. Even woolen "longjohns" were on the way, in readiness for the cold winter months ahead.

Through it all, the admiration that combat men traditionally have for medical personnel was apparent. One revealing incident will be long remembered by the nurses. A group of patients -- among them a front-line company aidman -- was being admitted. The other patients, upon learning he was a medical soldier, looked up from their litters. "A medic," they shouted, "take good care of him." "Give him the best in the house", or "Watch our Buddy -- he's all right!"

It is an important morale factor for a fighting man to know that not far away is a medical soldier, a surgeon or a nurse to give him the best possible immediate care. He should know, too, that he will be quickly evacuated to a higher echelon of medical treatment. The speed with which wounded men have been taken from the scene of injury and transported to a hospital has played a great part in determining the low fatality rate.

The knowledge that they are a valuable component of this vast medical team, and the fierce pride they feel in the Army Nurse Corps and in their own particular unit, has been ample reward, nurses of the 8055th Mobile Surgical Unit say.

The organization was prepared to roll up its sleeves and go to work soon after the long arduous return trip to Taejon. Thus, without change in pace, began the fourth month in Korea.

XI. Recent Department of the Army and FEC Publications



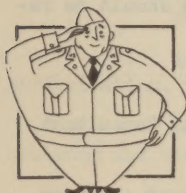
- AR 40-205, 27 Nov 50: Medical Service - Military Hygiene and Sanitation
- AR 40-610, 1 Dec 50: Medical Service - General Administration of Medical Treatment Facilities
- AR 40-685, 18 Dec 50: Medical Service - Hospital Local Broadcasting System
- AR 880-10, 18 Dec 50: Public Animals - Utilization of Horses and Mules
- AR 40-1080, C-3, 22 Dec 50: Medical Department - Current Statistical Health Reports, Tables and Charts
- AR 40-105, C-2, 3 Jan 51: Medical Department - Standards of Physical Examination for Commission or Warrant in Regular Army, National Guard of United States, Army of United States and Organized Reserves
- DA CIR 71, 15 Dec 50: Sec I Interservice Transfer; Sec IV Rates Authorized for Civilian Medical Services
- GO 44, 14 Dec 50: Sec I Army Environmental Health Laboratory
- SR 600-145-11, 9 Nov 50: Personnel - Assignment of Hospital Patients
- SR 40-410-10, C-1, 10 Nov 50: Medical Service - Central Facilities Provided for Department of Defense by Armed Forces Institute of Pathology
- SR 40-590-30, 13 Nov 50: Medical Service - Subsistence in Hospital Messes
- SR 41-20-10, 27 Nov 50: Hygiene and Sanitation - Trailer Camps
- SR 140-105-6, C-1, 29 Nov 50: ORC - Appointment in Army Medical Service Sections
- SR 55-765-5, C-4, 8 Dec 50: Transportation and Travel: Travel of Dependents To, From, and Between Overseas Area
- SR 40-10-45, 12 Dec 50: Medical Service - Medical Officer's Professional Training Record
- SR 40-1080-10, C-1, 21 Dec 50: Medical Service - Reporting of Bed Capacity and Bed Status Data by Fixed Medical Treatment Facilities
- SR 40-590-47, C-1, 3 Jan 51: Medical Service - Medical Services to United States Foreign Service Personnel and their Dependents in Medical Facilities of Departments of the Army and the Air Force
- SR 605-60-43, C-3, 5 Jan 51: Officers - Medical Officer Procurement - Professional Training Programs
- T/O&E 8-561, 11 Oct 50: Station Hospital, 25-Bed, Communications Zone
- T/O&E 8-562, 11 Oct 50: Station Hospital, 50-Bed, Communications Zone
- T/O&E 8-563, 12 Oct 50: Station Hospital, 100-Bed, Communications Zone
- T/O&E 8-7N, C-3, 15 Nov 50: Medical Company, Infantry Regiment
- T/O&E 8-15N, 15 Nov 50: Medical Battalion
- T/O&E 8-16N, C-3, 15 Nov 50: Hqs & Hqs Co, Medical Battalion
- T/O&E 8-17N, C-2, 15 Nov 50: Ambulance Co, Medical Battalion
- T/O&E 8-18N, C-4, 15 Nov 50: Clearing Co, Medical Battalion
- T/O&E 8-27, C-2, 15 Nov 50: Medical Collecting Company, Separate
- T/O&E 8-28, C-2, 15 Nov 50: Medical Clearing Co, Separate
- T/O&E 8-37, C-2, 15 Nov 50: Medical Company, Infantry Regiment, Airborne
- T/O&E 8-75N, 15 Nov 50: Armored Medical Battalion
- T/O&E 8-76N, C-3, 15 Nov 50: Hqs & Hqs Co, Armored Medical Battalion
- T/O&E 8-77N, C-3, 15 Nov 50: Company, Armored Medical Battalion
- T/O&E 8-317, C-2, 15 Nov 50: Medical Ambulance Co (Separate)
- T/O&E 8-7N, C-4, 16 Nov 50: Medical Company, Infantry Regiment
- T/O&E 8-18N, C-5, 16 Nov 50: Clearing Co, Medical Battalion
- T/O&E 8-28, C-3, 16 Nov 50: Medical Clearing Co, Separate
- T/O&E 8-77N, C-4, 16 Nov 50: Company, Armored Medical Battalion
- TM 8-240, Sep 50: Psychiatry in Military Law

PART II

TECHNICAL

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Emergency Treatment of Maxillo-Facial War Wounds	XV	13
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XII. Obesity - Colonel Francis W. Pruitt, MC, Medical Consultant, Med Sect, GHQ, FEC



Overeating and its resultant obesity are chronic with many people and occupation personnel are no exception. A number of individuals have been seen at our hospitals, dispensaries and physical examination boards who presented themselves in varying degrees of obesity. Obesity's toll on the cardiovascular system and its reduction in life's longevity is known to all lay personnel. A diet for weight reduction published on pages 10 and 11 this issue is a very effective one and easy to follow.

Many applicants for military duty have been rejected because of weight beyond the maximum amount; this latter amount is quite generous and weight beyond is considered by the medical profession to be deleterious to health. Applicants presenting themselves for military service who are beyond the maximum weight allowance should be advised by the local authorities to reduce and resubmit themselves for examination when weight reduction has been accomplished.

XIII. Influenza



In a recent issue of the Surgeon's Circular Letter¹ reference was made to the occurrence of influenza type B as a contributing factor to the increase in the occurrence of respiratory disease among U. S. forces in Japan during the early months of 1950. In the same article, the desirability for early laboratory confirmation of suspected influenza was pointed out and the measures necessary to obtain such confirmations were described.

In the current respiratory disease season (1950-51) the presence of influenza among occupation personnel in Japan was first suspected when the combined rates for common respiratory disease and influenza among military personnel began an upward trend during the early weeks of December. This combined rate was 81/1000/annum for the week ending 1 December, increased to 120 for the succeeding week and continued a moderate but steady upward trend to reach 244/1000/annum for the week ending 5 January. Reports for the two following weeks show some decrease in admissions for these infections. During the period discussed, the presence of influenza type A prime was demonstrated among occupation personnel in Japan through the study of serum specimens submitted to the 406th Medical General Laboratory. During this same period, an increased occurrence in the number of influenza cases among Japanese and the presence of influenza A prime in this group was reported by Japanese workers. No reports of significant rises in the occurrence of respiratory disease and influenza have been received from troops in the Far East Command outside of Japan, although there are indications that such increases may well have started among U. S. forces in Korea.

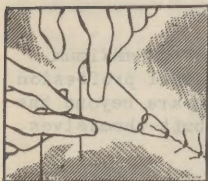
Influenza has made its appearance elsewhere in the world as well. An outbreak beginning in November was reported from Sweden, and from Denmark and Norway in December. Later that month and in early January, the disease made its appearance in England, apparently reaching at least semi-epidemic proportions there. Reports indicate that A prime strains have been responsible for the outbreak in Sweden and England. The disease has also recently been reported from Spain, Belgium, the Middle East, Greenland, and a number of islands in the South Pacific.

(¹ "Influenza" - Surgeon's Circular Letter, 1 November 1950, page 13)

The occurrence of influenza in the Far East Command has not so far approached epidemic proportions. There is, however, a continuing possibility of such an occurrence. With this in mind and in view of the outbreaks of the disease in other world areas, the vaccine offered by the Surgeon General was accepted and an influenza vaccination program instituted in Japan, Okinawa and Korea.

The vaccine being used is a polyvalent agent containing types A (PR-8 strain), B (Lee strain) and A prime (FM-1 and Cuppett strains). The latter strain (Cuppett) was isolated in the United States early in 1950 and studies made with it indicate that it possesses quite a broad antigenic coverage against A prime type strains. As with previous vaccinations, a single dose of 1 cc is administered subcutaneously. (The dosage for children should be reduced according to the weight of the child. As a guide, a 100 lb. child may receive the full 1 cc dose, while a 50 lb. child should be given one-half the full dose or 0.5 cc.) The vaccine is prepared in eggs, hence any individual giving a history of sensitivity to eggs or chicken meat should be excluded from vaccination. Desensitization should not be attempted. The proportion of those vaccinated in whom general non-specific type of reactions can be expected is not known. The Influenza Commission has stated that this proportion will not exceed one to two percent. Any significant deviation from this expected incidence of reactions should be reported through appropriate medical channels.

XIV. Notes on the Care of Battle Casualties - Colonel Frank E. Hagman, MC, Surgical Consultant, Med Sect, GHQ, FEC



The Army Medical Service cannot afford to indulge in complacency at any time. If it does not progress constantly there is danger of regressing. Considerable praise has been given the medical service for its conduct in the support of our forces in Korea. Deserving as this may be we are humbly aware of some deficiencies. Deviations from fundamental concepts in the care of battle casualties have occurred. These have frequently resulted in untoward complications and sometimes in disaster.

With the hope of improving upon the overall care of the wounded soldier attention is directed to certain facts which are not new but are sometimes overlooked or disregarded.

1. Initial debridement is a vital procedure which may affect the entire future course of the wounded patient. Complete excision of all devitalized tissue and foreign material cannot be accomplished by snipping at the surface. The aggressive surgeon opens the skin and fascia to the extent necessary in exposing the underlying devitalized tissue and foreign material. This is accomplished with scrupulous surgical technique and with complete regard for the anatomical structures of the part. The length of the incision is sufficient to enable exposure to be adequate whether it is 6, 12, or 18 inches in length. Skin is not sacrificed. Good lighting, free exposure, and hemostasis are essential. Counter incision through anatomical planes is frequently necessary for complete excision of damaged tissue and for instituting dependent drainage. Fine mesh gauze is placed in the wound lightly for the sole purpose of separating wound margins to promote drainage.

Disregard of the principle of complete excision of devitalized tissue and the removal of foreign material in the wound has resulted in severe infection, much suffering, delay in recovery and even death. Metallic foreign bodies, however, not in the wound itself should not be disturbed without specific indication.

2. Craniocerebral and penetrating wounds of the spinal cord are best treated by the neurosurgeon. Delay in and the incomplete performance of initial surgery frequently results in complications such as brain fungus, abscess, cerebritis, and focal manifestations from pressure and hematoma. Craniocerebral injuries require careful preoperative evaluation and therapy. Roentgen examination is extremely important to determine the extent of indriven bone fragments prior to surgery. Debridement of the wound must be complete. The defect in the skull should be enlarged so that all devitalized brain tissue and bone fragments can be thoroughly removed. After hemostasis is secured the dura is closed using fascial graft if necessary. Complete closure of the scalp completes the operation. Vigilant post-operative care is of great importance.

Since the neurosurgeon is best equipped to treat these cases it is desired that the facilities now available be used. The Navy Hospital Ships are supplied with neurosurgeons who are willing and anxious to do everything possible. It is contemplated to provide one or more neurosurgical teams soon in Korea to improve the treatment of these cases.

3. Maxillofacial wounds do much better when careful debridement, without sacrifice of skin, is followed by suturing the buccal mucosa, approximation of the muscles, closure of the skin with fine

non-absorbable sutures and the fixation of fractures in such a manner as to ensure safe transportation. Rubber bands between the maxilla and the mandible which can be removed promptly should be provided should vomiting supervene.

4. Eye injuries:

Emergency treatment in the field should consist of patching both eyes for severe ocular injuries.

All eye injuries should be treated as absolute litter cases and evacuated to the eye service. Many patients with retinal tears, retinal detachments, and intraocular damage have been received as ambulatory cases.

Delay in treating corneal laceration, prolapsed uveal tissue, superficial and intraocular foreign bodies and large defects of the lids cause irreparable harm.

Eyelids should be sutured together when the patient is unable to close the lids himself.

Antibiotics, locally and systemically, should be administered prior to evacuation.

Acute anterior and posterior uveitis should receive 1% atropine to the involved eye prior to evacuation.

Patients with corneal ulcers and corneal foreign bodies also should receive 1% atropine ointment and the eyes should be patched.

Purulent eye infections receive atropine locally; antibiotic and sulfonamide therapy topically and systemically. The eye is left open without patching or suturing the lids together.

5. Thoracic injuries caused by penetrating or perforating wounds require correction of the disturbance to the respiratory and cardio respiratory system and the prevention and treatment of infection.

Open pneumothorax is treated as soon as diagnosed by an occlusion dressing. The wound is debrided at a forward hospital and the chest wall closed, leaving the skin unsutured. Damaged tissues, bone fragments, and blood are removed. Hemostasis is assured and the lung expanded. Underwater catheter drainage is established when there is danger of pressure pneumothorax. The chest is aspirated as frequently as necessary until it is considered to be dry.

In hemothorax the principle of aspiration until the chest is clear pays great dividends. In most instances this has been practiced conscientiously.

6. Abdomen: Failure to apply a few of the basis principles of treating abdominal injuries occurs in some instances.

Patients who have had laparotomies withstand transportation poorly for the first week or ten days following repair of injuries.

Stab wound drains for injury to the liver appear to prevent the accumulation of bile in the abdominal cavity.

Cholecystectomy or repair of the perforated gallbladder with cholecystostomy is a better procedure to avoid accumulation of bile which occurs from an attempt to repair the gallbladder primarily.

Any wound of the abdomen or its vicinity which could conceivably injure a hollow viscus requires laparotomy if the condition of the patient permits. Laparotomy is the only certain means of knowing whether damage has occurred. What appears to be an insignificant wound may produce numerous perforations of the hollow viscera.

Perforation of the large intestine requires exteriorization of the part through a separate incision and after adequate mobilization to avoid tension. Primary closure of these wounds frequently results in abscess, fecal fistula and deterioration in the general condition of the patient. Exteriorizing through the laparotomy incision frequently is followed by severe wound infection and disruption of the wound.

Rectal injuries are sometimes overlooked. This has occurred with gun shot wounds of the buttock and upper thigh. The wise doctor will always insert a finger into the rectum in these cases

(Turn to Page 12)

REDUCING DIET

If you faithfully adhere to the simple instructions outlined below, this diet will cause you to lose from 15 to 35 pounds in 12 weeks. In order to fulfill your wish it is necessary for you to have a tenacious determination to adhere strictly to this regime, because it is you and only you who can successfully accomplish your aim. Obesity is always due to excessive eating, often the result of unoccupied time, frustration, or worry.

Eat as much as you like of lean meat, (except pork), poultry, liver, heart cooked in any way, but without the addition of flour, bread crumbs, butter or thick sauces. All meat to have all fat trimmed off.

Fish, fresh or frozen, shrimp and shellfish boiled, baked, or steamed, with no thick sauces, butter, or creamed gravy.

Eggs, boiled or poached.

Cheese, cottage cheese only. All other cheeses are 20 to 44% butter fat.

Vegetables. From the list published. The percentage indicates the carbohydrate content, hence 3% vegetables (Group I) are much to be preferred to 9%. Preparation is not to include the use of fat or starch or sauces.

Salads. These may be selected from the listed vegetables or fruits and served without mayonnaise, or oil. Vinegar or lemon may be used as a dressing.

Fruits. Select from the published list which are grouped according to the carbohydrate content. Here again 3% fruits (Group I) are preferred to those of 15 to 18%. Also water packed canned fruit, but no canned or frozen fruit packed with sugar; no dried fruit, such as dates, figs, prunes, or raisins.

Soups. Clear broth, consomme, bullion, or jelled consomme, thin vegetable soup without fat, rice, barley, noodles, or other starches and fats.

Condiments: Salt, pepper, mustard, vinegar, Worcestershire sauce, mineral oil dressing. No other sauces. Sour pickles but no sweet pickles. Saccharine for sweetening.

Beverages: Tea and coffee without sugar or cream. Fat free buttermilk, and skim milk, one pint daily.

Bread: One piece of toast for breakfast.

You may have nothing else whatsoever, particularly noting that this means no butter (except 1/2 pat at breakfast), margarine, fat or oil. No sugar, jam, marmalade, honey, sweet chocolate, cocoa, cereals, dried or salted fish. No puddings, ice cream. No thick or creamed soups. No pork, bacon, sausage, or goose. No potatoes, macaroni, spaghetti or rice. No beer, wine, or spirits because:

- 1 bottle of beer (12 oz) = 1/2 cup of ice cream = 1 piece of apple pie
- 2 Martinis = 1 roast beef sandwich (85 proof) 1 1/2 oz each (3/4 inch sector)
- 1 rum and cola = 3 sweet rolls = 2 slices of toast

The published menu may be used as a guide.

Weigh before you begin and thereafter weekly in your physician's office in the same weight clothes and at the same time of the day.

Vitamins: One (1) Multiple Vitamin tablet should be taken three times daily during this reduction regime.

Strenuous exercise is to be avoided as this will generally increase the appetite. Normal exercise is indicated.

Avoid any drugs, such as thyroid, benzedrine, doxedrine, etc., unless prescribed by your physician.

It is indeed true that the circumstances leading to gluttony and to alcoholism are much the same and that the results are about equally harmful.

It is a well established fact that between the ages of 45 and 55, 25 pounds of excess weight means a 25% increase in the chances of your dying within the next year. Fifty pounds excess means a 50% greater chance of death. More weight increases the hazard in proportion.

CARBOHYDRATE PERCENTAGE IN VEGETABLES

GROUP I	GROUP II	GROUP III	GROUP IV	GROUP V	GROUP VI
3% Carbohydrate	6% Carbohydrate	9% Carbohydrate	12% Carbohydrate	15% Carbohydrate	18% Carbohydrate
Asparagus, fresh and canned	Beans, scarlet runner	Artichokes, globe or french	Beans, lima, canned	Corn, sweet, very young	Beans, baked
Bamboo shoots	Beets, canned	Beets	Brussels sprouts	Jerusalem artichokes, tubor	Beans, red kidney, canned
Beans, green & wax	Chives	Brussels sprouts	Carrots	Parsnips	Corn canned
Beet greens	Callards	Carrots	Onions	Peas, medium	Potatoes
Broccoli	Dandelion greens	Onions	Beans, very young	Salsify	Succotash, canned
Cabbage	Eggplant	Peas, canned	Butabagas	Vegetable-oyster	
Cabbage, Chinese	Kale				
Cauliflower	Kohlrabi				
Celery	Leeks				
Chard	Okra				
Chicory leaves	Peppers, green & red				
Cucumbers	Pumpkin				
Endive	Pumpkin & Squash, canned				
Mustard Greens	Turnips				
Okra, canned					
Radishes					
Fennel					
Sauerkraut, fresh & canned					
Spinach, fresh & canned					
Squash, summer					
Tomatoes, fresh & canned					
Tomato juice, fresh & canned					
Turnip tops, fresh & canned					
Vegetable marrow					
Watercress					

CARBOHYDRATE PERCENTAGES IN FRUITS*

GROUP I	GROUP II	GROUP III	GROUP IV	GROUP V	GROUP VI
3% Carbohydrate	6% Carbohydrate	9% Carbohydrate	12% Carbohydrate	15% Carbohydrate	18% Carbohydrate
Rhubarb, fresh & canned, w.p.	Blackberries, canned, w.p.	Applesauce, canned, w.p.	Apple juice	Apples	Cherries, sweet
Strawberries, canned, w.p.	Blackberry juice	Apricots, canned, w.p.	Apricots	Blueberries, fresh and canned	Crab apples
	Gooseberries, canned, w.p.	Blackberries	Cherries, sour	Blueberry juice	Figs
	Peaches, canned, w.p.	Cherries, red, canned, w.p.	Guavas	Figs, canned, w.p.	Grape juice, unsweetened
	Plums, canned, w.p.	Cranberries	Mulberries	Grapes, American & European types	Persimmons
	Strawberries	Currants	Orange juice	Kumquats	Japanese Pomegranates
	Watermelon	Gooseberries	Peach juice	Loganberries	
		Grapefruit, fresh and canned, w.p.	Pineapple, fresh and canned, w.p.	Mangoes	
		Lemons	Pineapple juice, fresh and canned	Nectarines	
		Lime juice	Plums (excluding Prunes)	Pears	
		Limes, sweet	Raspberries, black & red		
		Loganberries, canned, w.p.			
		Papayas			
		Pears, canned, w.p.			
		Raspberries, canned, w.p.			
		Rasperry juice			
		Tangerines			
		Loganberry juice			

(* The canned fruits included here are all water-packed products, designated as w.p. in the lists.)

BREAKFAST:

- 1 serving of fresh fruit of glass unsweetened fruit juice
- 1 egg, any style, prepared without fat
- 1 slice toast
- 1/4 pat butter
- 1 glass skim milk, black coffee

DINNER SUPPER:

- Medium serving lean meat
- 2 medium servings 3% vegetables (no butter or cream), salad, preferably raw vegetable or fresh fruit (no salad dressing)
- fresh fruit for dessert (average serving)
- 1 glass skim milk, black coffee or tea with lemon

BREAKFAST

- glass tomato juice
- 1 boiled egg
- 1 slice toast
- 1/4 pat butter
- 1 glass skim milk, black coffee

LUNCH

- roast beef (no gravy)
- peas
- stewed tomatoes
- lettuce w/vinegar
- fresh apple
- 1 glass skim milk, black coffee or tea with lemon

DINNER

- clear broth
- lamb chop (no fat)
- carrots
- spinach
- raw celery
- orange
- 1 glass skim milk, black coffee or tea with lemon

to determine whether blood is present or not. The treatment of rectal injuries always should be by a complete defunctioning type of colostomy that diverts the fecal stream. The perirectal spaces should be opened and drained. Injuries to the rectosigmoid region which cannot be exteriorized should be closed and the fecal stream diverted by a proximal defunctioning type of colostomy. This means the separation of the proximal and distal loops of the colon to prevent feces from the proximal loop to enter the distal loop.

When fecal contamination of the peritonium is present, care should be exercised in suturing the laparotomy incision. Many of these wounds have become severely infected. These are in cases in which the wound has been closed tightly including the skin. It is suggested that all of the layers be approximated by a through and through non-absorbable suture without tension and without suturing the skin.

Suprapubic catheters must be placed high in the fundus of the bladder to avoid injury to the trigone.

A conservative attitude should guide the surgeon in wounds of the kidney. The kidney must not be removed for injuries involving one pole. Only irretrievably damaged kidneys should be excised. Careful follow-up may reveal the necessity for nephrectomy subsequently.

7. Extremities:

Circular amputation with application of skin traction immediately and continuously is the only accepted procedure in war injuries which require amputation. Deviations from this have resulted in infection, sacrifice of tissue, and necessity for reamputation at a higher level.

Every circular plaster cast must be split to the skin before the patient is evacuated.

Windows in plaster casts should be avoided during transportation. Herniation of soft tissue into the window frequently occurs.

Cast should be well-padded. This should include the region of the head of the fibula. Peroneal palsy has occurred which may be attributed to pressure from the cast.

Velpeau plaster cast is superior to the hanging cast in the transportation of fracture of the humerus.

The patient with an injury to an extremity in which the blood supply is compromised should be held at the first hospital until the question of the adequacy or inadequacy of the circulation has been settled. The transportation of such a patient may result in further ischemia and the necessity for amputations. All measures to improve the circulation should be instituted at the first hospital.

The application of internal fixation to an open fracture in a forward hospital is courting disaster.

Cold injury of the extremities must be treated with utmost conservatism. Surgical procedures, except in emergencies resulting from overwhelming infection, should be postponed until definite indications arise. Complete demarkation must be awaited before amputation is considered unless sepsis indicates otherwise.

Open fractures of the long bones should be returned to the ZI at the earliest possible time commensurate with the safety of the patient's condition. The object is to get the patient to the ZI for definitive treatment of the fracture as early as possible and within the golden period.

Make a record that is informative. Knowledge as to what has transpired in the care of the battle casualty is necessary if further care is to be given intelligently. All too frequently the patient arrives in hospitals to rear without sufficient information regarding the nature of the wound, the operative findings, and what was accomplished by the operation. The patient has a laparotomy wound. He does not know what was done. Nothing appears on the record to enlighten the doctor who is now responsible for further treatment and decision as to disposition. This is unfair to the doctor and the patient. A descriptive note on the record accompanying the patient, written with the objective in mind of informing your colleagues to the rear, is mandatory.

XV. Emergency Treatment of Maxillo-Facial War Wounds - Major Jack P. Pollock, DC, 3d Station Hospital, APO 59



Because the dental officer serves in all echelons of medical evacuation, from the first echelon rearward, it seems of practical value to review some of the basic principles in early treatment of war wounds of a maxillo-facial nature.

Each step in the management of maxillo-facial wounds is of vital importance, so no attempt will be made herein to place them in significant sequence. It is not the purpose of this brief treatise to discuss specific techniques, but rather to present an informal, non-technical discussion of a topic of increasing importance to dental officers in this critical era. Nothing new is included. The purpose is to review a phase of dental surgery which concerns us today more than it has for the past few years.

Immediately upon seeing a patient with a maxillo-facial wound it is necessary to control hemorrhage, if there is any, to ensure that the intake of air is adequate. The control of hemorrhage can usually be accomplished by the use of hand pressure, pressure bandage, clamps, or by the ligation of the bleeding vessel or vessels. If the blood vessels are not readily accessible for ligation, it is best that this be accomplished by a surgeon because of the complexity of the vascular system of the maxillo-facial region.

Respiration is frequently impaired by foreign bodies, portions of bone or tissue or the tongue. An attempt to place the fragments of bone or soft tissue in a position as nearly normal as possible will often aid in improving the air intake as well as decreasing the hemorrhage. A supporting bandage, such as the Barton bandage familiar to all dental officers, is almost a necessity in this phase of treatment. It is sometimes necessary to secure the tongue by the use of a suture or a clamp to prevent the blockage of air-passages. Any foreign bodies preventing proper air intake should be removed. Tight fitting clothing about the throat and upper body should be loosened or removed.

Shock is encountered all too often in severe maxillo-facial injuries in battle casualties and should be treated accordingly. It is mentioned here only to bring out its prevalence in wounds of this nature. Plasma is almost always available and its early use can and will prevent shock in many cases. This is a point well worth remembering.

Control of pain is another all-important factor. It is usually accomplished in early treatment by the ever-reliable morphine tartrate syrettes, which provide a quick and convenient means. The control of pain as an adjunct in the overall treatment is not likely to be underrated.

Treatment is of necessity anything but definitive in the first, second and frequently third echelons of the medical evacuation chain. The lack of time and the frequent overwhelming volume of patients preclude definite treatment. The removal of obvious foreign bodies and the closure of lacerations should be accomplished. Gaping wounds with extensive loss of tissue cannot and should not be closed. In the debridement of severe maxillo-facial wounds there is one important point to keep in mind at all times - conservation of tissue. This is important because of the necessity for future plastic surgery which in most cases will be inevitable. The closure of lacerations on the face should be accomplished with silk or cotton sutures and never with the use of gut sutures. Gut sutures are used only in intra-tissue work. This is an important factor as the use of gut on skin surfaces can be the cause of considerable disfigurement. Sterile vaseline gauze should be applied to all wounds of the face before the dry dressings are applied. Perhaps this seems a superfluous statement but it was overlooked in many instances. The use of vaseline gauze aids in the removal of dressings without pain to the patient. Aside from this, dried dressings become attached to the wound and often cause bleeding upon removal.

Reduction of fractures of the mandible or maxilla is neither advisable nor is it often possible in forward areas in the majority of cases. Because of edema and the patient's general condition, it is frequently impossible to reduce fractures even in third echelon installations. Hence it is good practice in examining the patient, to keep in mind the points mentioned herein - change dressings if necessary, and evacuate the case to a fixed installation as expediently as possible.

It has been my observation that a large percentage of maxillo-facial fractures from missiles in a combat zone are of the compound, comminuted type often accompanied by considerable loss of both soft and bony tissue. The management of such cases requires long periods of time and should be left to those with training and experience in this field. They should only be handled in fixed installations where adequate facilities and well-trained personnel are available. It is, therefore, to the patient's advantage that he be returned to such installations with the least possible delay.

To summarize, the basic principles for early treatment of combat incurred maxillo-facial wounds are:

1. Check air passages to ensure adequate intake of air - (remove obstructions: foreign bodies, tissue, clothing, etc.)
2. Control hemorrhage.
3. Prevent or treat shock.
4. Immediate treatment -
 - a. Debride cautiously
 - b. CONSERVE TISSUE
 - c. Close lacerations using silk or cotton sutures
5. Do not attempt too much.

This paper is submitted as a resume of acceptable methods for the early management of severe maxillo-facial wounds. It is sincerely hoped it will be accepted only as such.

XVI. Burns - Consultants Division, Medical Section, GHQ, FEC



During the past few weeks a Surgical Research Team consisting of Lt. Colonel Edwin Pulaski, MC, and Major Curtis P. Artz, MC, has made a study of 48 burned patients. The majority of these patients were transferred from Korea.

The study disclosed the burns had been managed by applying vaseline gauze and an absorptive type of dressing. Cleaning and trimming of the burned area had been omitted except in one case. In almost every patient, bacterial putrefaction and wound cellulitis complicated the wounds.

The vaseline gauze dressings usually were occluded by a solid sheet of fibrin. Drainage, therefore, was impeded and evidence was obtained that wound healing time was prolonged. Every surgeon responsible for the treatment of the burned patient has had a similar experience.

The treatment of the burned patient has changed over the years, and is still in the process of modification. As in other fields of medicine, the burned patient is considered as a whole and not in terms of isolated damaged parts. The burn frequently produces profound physiologic disturbances demanding correction. At the same time, local treatment is of utmost importance to prevent and control infection, to prevent contractures, to hasten repair and to restore the organism to a normal functioning whole.

CORRECTION OF DERANGED PHYSIOLOGY

Many methods are used to estimate the requirements for fluid replacement in the burned patient. It is held at the present time that the adult patient with burns involving less than 15% of the body surface can be hydrated satisfactorily with fluids by mouth without the necessity of parenteral administration. For larger areas of the body surface, a quick estimate of the intravenous fluids needed can be made, utilizing the following:

Body Sectors of Nine

Head and neck.	9%	of	body	surface
Each upper extremity	9%	"	"	"
Each lower extremity (2x9)	18%	"	"	"
Trunk anterior (2x9)	18%	"	"	"
Trunk posterior (2x9).	18%	"	"	"
Perineum	1%	"	"	"

Formula

Protein 1 cc(blood preferred per kilo body weight,
times the % body surface involved.
Electrolyte - Use same formula.

Example: 30% (regardless of depth) in 70 Kilogram male
 Blood 1 x 70 x 30 = 2100 cc
 Electrolyte 1 x 70 x 30 = 2100 cc

One-half of the calculated amount is given the first eight hours, one-fourth the second

eight hours and the remainder the ensuing eight hours.

The second 24 hours of blood and electrolyte administration is one half of that of the first. Thereafter, intravenous fluid administration is on the basis of established indications.

For burns, more than 25% of the body surface, a Foley catheter is introduced into the bladder. Additional fluids by mouth or vein are given to maintain the urinary output to 60cc per hour.

Overloading with fluids is avoided when the patient is severely burned, when he has sustained inhalation burns, and when lower nephron nephrosis is suspected.

A patient with a satisfactory urinary output and no complications should be ready for evacuation on the third day.

LOCAL TREATMENT OF BURNS

With satisfactory response to the measures for the correction of deranged physiology, local treatment may be carried out. This can be done usually with morphine analgesia. The burned surface is cleansed with a detergent such as Phisoderm, if available, containing 3% hexachlorophene; or by plain bland soap and water. All blisters are broken and the surface thoroughly cleansed of all devitalized tissue. This can be accomplished usually by using a dry sponge or thumb forceps and scissors. A second wash is then accomplished gently without traumatizing surviving epithelium.

PATIENTS REQUIRING EVACUATION

To the cleansed burned surfaces, absorptive dressings are applied when the patients must be evacuated. Vaseline gauze dressings are strictly avoided. Fine mesh gauze is placed upon the surface of the burn. To this is applied large absorptive dressings.

PATIENTS NOT REQUIRING EVACUATION OR WHO HAVE BEEN RECEIVED AFTER EVACUATION

The dressings are removed. If local care has been inadequate, these measures are carried out. The burned areas now are treated by exposure. The patient is placed in bed and the burned areas elevated, if possible. Stryker frame may facilitate exposure of burns of the trunk. Within 30 to 48 hours a dry, firm crust will form. A cool room, a cradle without lights to hold the bed covers away, and clean sheets will promote the formation of the coagulum. The patient should be turned frequently to aid exposure when necessary. Extremities may be elevated by appropriate means.

In partial thickness burns, the crust will desquamate spontaneously on about the 14th day past burn. The crust over a full thickness burn will become extremely thick and firm. Unless a break occurs, the fluid which collects beneath it remains sterile. Should a break occur, infection will require removal of the crust and the application of a fine mesh gauze dressing.

If the eschar remains intact, it can be removed surgically between the 18th and 21st day. Two days later split thickness grafts may be applied.

In areas covering joints where early function is desired, such as hands, elbows and knees, the eschar may be removed surgically between the 6th and 9th day followed by the application of split thickness grafts.

ANTIBIOTICS

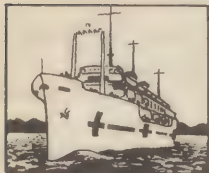
800,000 units of aqueous penicillin are given on admission of the patient, followed by 300,000 units of procaine penicillin daily. No antiseptic or antibiotic drugs are applied to the burned areas.

Summary of aims of treatment (Wallace of Edinburgh)

1. To correct pathologic physiology.
2. To produce an environment of the burn surface unfavorable to the growth and multiplication of bacteria by:
 - a. Production and maintenance of a dry surface;
 - b. Exposure of surface to light;
 - c. Reduction of the temperature of the surface to below that of the body.
3. To apply local care which is bland to tissue cells.
4. To provide rest of the affected part by immobilization.

5. To limit edema by elevation.
6. To render nursing care simple.
7. Surgeons should always be aware of the fact that burns constitute the largest of open wounds.

XVII. Medical Evacuation and the Gain in Illness - Colonel Albert J. Glass, MC, Neuropsychiatric Consultant, Med Sect, GHQ, FEC



The fact that illness often represents a gain for the individual seems paradoxical since disease is generally considered as a disaster or at least a painful, crippling episode. The pain, discomfort, restriction of activity, and possible danger to life has always made man fearful of disease and its consequences. To obtain security from this threat there have been steady strides in the prevention and treatment of all types of disease. However, doctors of medicine are quite aware that illness is often utilized by the individual as an honorable escape from disagreeable tasks or onerous obligations. In the psychiatric field hysterical patients develop such syndromes as extremity paralysis, blindness, and deafness which mimic bodily disease and are the result of an unconscious attempt by the individual to solve an emotional conflict by the compromise of disease.

Man, in common with the other animal species, obeys the biological principle of avoiding pain and displeasure while striving for gratification and pleasure. Pleasure is used here as a general term to include personal security, shelter, food, satisfaction of sexual needs, and the gratification of ambition and achievement. Displeasure comprises physical danger and pain, thirst, hunger, and frustration in career and work. It is important to note that while all human beings follow the pleasure-pain principle, in many instances pleasure and displeasure become relative matters depending upon the individual and the culture in which he is raised. The Chinese soldier does not experience as much displeasure as the American soldier in withstanding the deprivation of food, shelter, and the discomforts of the field. Some Americans cannot even tolerate separation from their wives or mothers and experience so much displeasure that they become literally sick and ineffective.

At this point it is pertinent to examine the American culture and note the role that illness plays. Generally our children and adolescents are carefully protected against physical harm, pain, and discomfort. Their aggressiveness is curtailed because it may lead to injury or harm to others. Yet we also teach and stress courage, initiative and aggressiveness, particularly in career and ambition. To put this more simply, our culture overly protects the young while at the same time exhorting him ideologically to be aggressive, bold, and ambitious. The result is that frequently the adolescent male is relatively helpless and fearful when faced with physical hazards but in his day dream fantasies he is an all-conquering hero, similar to what is portrayed on the screen and in the comic books. This type of adjustment is adequate for the adolescent but as an adult and more specifically as a combat soldier he has to perform hazardous duty, withstand severe physical discomfort, and be aggressive enough to destroy the enemy. For many of our combat soldiers this change or adjustment is difficult and in some cases impossible.

To this problem of the adjustment of the combat soldier illness and injury comes as an honorable compromise which brings back the childhood protection and care and yet relieves him of the obligation which is demanded of him as an adult and a combat soldier. The advantages of illness do not come as a surprise to the soldier. In childhood he could not have failed to note the increase in love and affection from his environment that regularly accompanied episodes of illness. He knew that illness was the major cause for being excused from school or other daily and sometimes disagreeable obligations. In peacetime and in garrison duty, illness again was the only method of being excused from strenuous or disagreeable tasks. The sick call line is large when a long march is ordered but melts away when holiday leaves are being granted.

The combat situation with its stresses and hazards crystallizes the pleasure-pain principle. It is not unnatural for the combat soldier to watch with envy the evacuation of his lightly wounded or injured buddy. The term, "million dollar wound" has become part of his vocabulary. Literally he is stating that a non-serious wound is worth a million dollars to the individual. The euphoria of the wounded soldier is a common observation. It extends to the even more seriously wounded who have been relieved of pain. It is not surprising or unnatural for the combat soldier to have wishes in this direction, conscious or unconscious, which affect his motivation in connection with the seeking of medical evacuation for disease or injury. This is directly reflected in the phenomena of SIW, (self-inflicted wounds), and other careless accidents which increase with the hazards of combat. It is also demonstrated in the large number of broken spectacles and dentures which cause at least a temporary

removal from battle. More numerous than the foregoing are other non-battle casualties who are evacuated from the combat situation. Many of these cases have mild medical and surgical conditions or no objective findings but only subjective complaints.

The combat psychiatric casualty breaks down and admits that he cannot stand the continuous stress of battle. The mild non-battle casualty has a similar difficulty but tries to avoid an internal conflict with his own conscience by placing the cause of his inability to perform to physical factors which are not his responsibility and beyond his ability to control.

Once an illness or injury, regardless of cause or severity, has removed the individual from battle the gain incident to such removal becomes a factor which often acts to prevent a return to combat duty. His gain in illness becomes more fixed dependent upon the distance and length of time he is away from the combat area. The current rapid, efficient air evacuation is a splendid and commendable advance in field medicine, but for the mild medical and surgical case the gain in illness mechanism is increased. It becomes more difficult to return such patients to duty and the individual is lost to his unit for an amount of time disproportionate to the severity of his condition.

In the hospital it is common to find patients clinging desperately to symptomatology in an effort to keep the gain which has resulted from the disease or injury. Complaints of headache, backache, weakness, painful joints and scars are frequent and are resistant to treatment. Such patients often are resentful. They claim nothing is being done for them and indignantly deny that they are trying to avoid duty, but rather stress that their pain or discomfort makes it impossible for them to keep up or perform strenuous physical exertion. Such statements as, "Cure my back and I'll be glad to go up there", or "I'm no good to them if I can't keep up", are common. Physiological and psychological explanations are usually wasted as the individual usually insists that he has his pain and "doesn't imagine it".

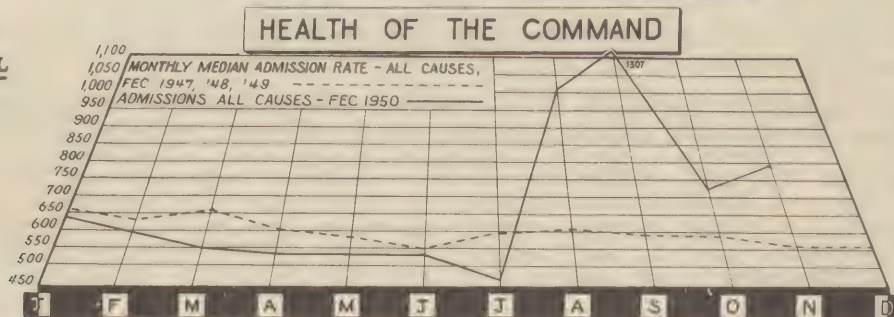
What should be the role of the medical officer in handling this drive to escape a difficult situation via medical channels. If the medical officer stationed in battalion or regiment yields to subjective complaints or non-disabling conditions and evacuates such individuals he only creates loose medical discipline and a larger number of soldiers are stimulated to try the medical escape route. The medical officer is also affected by the situation. If he endures combat hardship it is human to identify with the soldier, actually feel with him, his dilemma, and be subconsciously influenced to accept subjective complaints as valid criteria for evacuation. In a rear position or hospital the medical officer often feels guilty when returning individuals to a more dangerous environment than he fortunately does not have to endure. Medical officers often try to solve their own dilemma by resorting to rationalizations, sometimes quite true, that they cannot hold patients and study their cases thoroughly, that he does not have laboratory and other diagnostic facilities to disprove the patient's complaints, and that the next hospital has more time and facilities. In so doing the medical evacuation is either initiated or continued and with each hospital being crowded the patient is moved along with a consequent increase in the gain in illness as he is efficiently moved further to the rear. In the rear hospital in Japan the medical officer has to contend with the gain in illness strengthened by time and distance. The soldier cured of his flesh wound, mild fracture, minimum frostbite, diarrhea, or febrile episode begins to develop symptoms with the healing of his disease or injury. It is also influenced by further possible gain as he watches the seriously ill and injured cases being sent to the ZI.

There is no easy answer to this problem which is so deeply rooted in basic biological demands. It is particularly difficult for the medical officer because his training conditions him to sympathize with suffering and to be persistent in the removal of the symptoms of his patients. The medical doctor likes to have satisfied and grateful patients, to be personally liked and complimented. Yet to perpetuate and be influenced by the gain in illness is to do poor medicine, to stimulate others to avoid their obligations and to be ineffective in the mission of the Army Medical Service which has for its purpose the conservation of the fighting strength of the Armed Forces.

The only effective and reasonable solution for the medical officer in this difficult matter is to be a medical doctor and to rely on his specialized medical knowledge. He cannot let himself be influenced by his emotional feeling of who should or should not be sent to combat duty. The medical officer is not an expert on justice, military strategy, or geopolitics. He is a soldier equipped with a specialized technical skill to do the job for which he is assigned. Regardless of where the medical officer is stationed his function is clear and unequivocal. Patients must be reasonably examined and evaluated. If the individual is disabled for duty and requires further treatment not possible at the particular time or level in which he is operating then medical evacuation is indicated. But if the soldier has no objective findings and only subjective complaints he is not disabled and must be promptly and firmly returned to his unit. Acrimonious disputes with the patient and long explanations are of little value. Becoming angry at the patient or tearful with him does not help anyone. The soldier should not be told to "try it again and see your battalion surgeon if you have any trouble", because this implies doubt on the part of the medical officer and confirms patient belief that his symptoms

are valid. In most instances the medical officer can trust his clinical judgment. Unnecessary and elaborate diagnostic surveys serve only the purpose of allaying the anxiety of the doctor when he tries to disprove all of the patients symptoms. If there is a reasonable doubt in the mind of the medical officer diagnostic procedures are indicated and valid, but this should be a clinical impression and not stem from the emotional insecurity of the medical officer. It is only by the use of a fair, reasonable and objective clinical approach that the medical officer can best perform his role in what is admittedly a difficult time for all. The unwillingness of a soldier to return to combat duty is quite understandable but this is not a professional matter for the doctor to enforce and properly falls under the function of Command. It is pertinent to reiterate that the medical officer is not actually the arbiter of the fate or destiny of the soldier. He is only a technical expert whose function is the evaluation, management, and treatment of disabilities resulting from mental and physical disease or injury.

PART III
STATISTICAL



Admission rates per 1000 troops per annum for the four week period ending 24 November 1950:

	FEC	JAPAN	KOREA	MARBO	PHILCOM (AF)	RYCOM
All Causes	793	559	987	367	416	585
Diseases	610	506	709	267	360	503
Injuries	118	53	163	99	50	74
Battle Casualties	66	.47	115	0	5.4	7.1
Psychiatric	19	15	24	0	7.2	7.7
Common Respiratory Diseases and Flu	65	64	68	55	41	59
Primary Atypical Pneumonia	2.6	.78	3.8	0	0	3.6
Common Diarrhea	16	2.7	27	0	0	5.3
Bacillary Dysentery	.62	.16	.68	0	1.8	1.8
Amebic Dysentery	.62	.78	.60	0	1.8	0
Malaria, new	1.0	.31	1.5	0	0	1.2
Infectious Hepatitis	10	3.6	16	0	3.6	4.7
Mycotic Dermatoses	3.4	1.6	5.0	0	3.6	.59
Rheumatic Fever	.53	.47	.43	0	5.4	0
Venereal Diseases	119	154	93	14	99	201

All Causes Admission Rate:

In November, the rate of admission to hospital, quarters and dispensary for all causes for Army and Air Force personnel of the Far East Command was 793 per thousand strength per year, as against 730 in October. This increase in rate is the result of increases by Korea from 892 for the previous month to 987, and RYCOM from 513 to 585. MARBO experienced a minor increase in its rate while Japan and PHILCOM (AF) had minor decreases.

The disease component of the all causes admission rate increased from 573 in October to 610 in November. As in the case of the increase in the all causes rate, here again the increase is attributable to increased disease incidence in Korea and RYCOM. The rates for Korea and RYCOM for October and November were 639 - 709 and 467 - 503 respectively. Korea's increase in disease rate results from increased incidence of psychiatric condition, infectious hepatitis and venereal disease. RYCOM's increase was less demonstrable by specific diseases. PHILCOM (AF) and MARBO had rather minor decreases in their rates while Japan's decrease from 540 to 506 was more marked.

A minor increase was noted in the nonbattle injury component of the all causes rate for the month. The rate was 108 in October as compared to 118 in November. Japan and PHILCOM (AF) had slight decreases whereas Korea, MARBO and RYCOM experienced increases. The cold injury rate of 23 in Korea more than accounts for its overall increased rate from 158 to 163 for nonbattle injuries.

The Far East Command's battle casualty admission rate for November represents a slight increase from 50 in October to 66. In Korea alone the rate for this admission increased from 96 per thousand strength per year to 115 in November.

In November, the average daily non-effective rate of 29 for all causes per thousand troops per day was identical to the rate for the previous month. In comparison with the preceding month, only Japan and Korea of the major commands experienced any notable change. Due primarily to the tactical situation, the evacuation period for patients in Korea during November was increased and resulted directly in an increase in the non-effective rate for that command from 9.5 in October to 16 for November. Coexistent with this increase, and resulting directly therefrom, was Japan's decrease from 66 to 60 for the same period.

Diseases:

Common Respiratory Diseases and Influenza: The rate of 65 per thousand strength per year for common respiratory diseases and influenza in the Far East Command for November is a minor increase from the previous month at which time the rate was 60. All major commands reported a similar minor increase. The incidence of these diseases in the Far East Command compares favorably with experiences for the same period in 1948 and 1949 at which times the rates were 81 and 59 respectively.

Psychiatric: An increase in the psychiatric rate from 11 in October to 19 in November was noted; however, this is not remarkable when compared to 18, 88 and 56 for the months of July, August and September of this past year. Korea's increase from a rate of 11 for the previous month to 24 was the only command experiencing a notable increase. Japan's rate increased slightly from 11 to 15, while the other commands experienced no particular change.

Malaria: The rate for new cases of malaria in the Far East Command decreased from 3 in October to 1 in November. The FEC rate of 1 compares favorably with rates for the same period in 1948 and 1949 of 3 and .76 respectively.

Diarrhea and Dysentery: The incidence of intestinal diseases infections for the command declined from a rate of 26 for the preceding month to 20 in November. This is a higher incidence rate than was experienced for this period in past years; however, among the major commands, Korea is the principal contributor and the FEC rate as well as Korea's rate is the lowest experienced since the beginning of the Korean conflict.

Poliomyelitis: 2 cases of poliomyelitis were reported from Korea in November. This brings the total to 80 cases occurring among all occupation personnel in the FEC for the year. The previous report for the month of October showed a total of 81 cases; however, the diagnosis on 3 of the cases was changed, making a total of 80 cases through November.

Infectious Hepatitis: A considerable increase was noted in the infectious hepatitis rate for November. The FEC rate in October was 3.4 as compared to 10 for this month. Among the major commands the only significant change in the incidence of this disease occurred in Korea where the rate increased from 4.6 for the previous month to 16 in November. 85% of all cases of infectious hepatitis reported during the month occurred among personnel in Korea.

Venereal Diseases: The rate for total venereal disease per thousand strength per year for the command for November was 119. This is an increase from 104 for the month of October and results entirely from Korea's increased rate of 93 as compared to 54 for the preceding month. This increase is not unexpected. In fact, depending on the military situation, the occurrence of venereal diseases in Korea may well approach or even exceed that in Japan and Okinawa. Japan, PHILCOM (AF) and RYCOM reported minor decreases when compared to their October rates. MARBO, whose rate is very low, had an insignificant rise from 12 to 14. For comparison with the FEC November rate of 119 for total venereal diseases, the annual rate for 1947, 1948 and 1949 was 95, 102 and 161 respectively.

Deaths: 185 deaths were reported by medical treatment facilities in the Far East Command during November. Of these, 122 occurred among battle casualties, 47 among nonbattle injury cases and 16 resulted from diseases.

Evacuation:



Tabulated below are the number of patients evacuated from the major commands to the ZI during the four report weeks in November and the number of patients awaiting evacuation as of 24 November 1950:

	BY AIR	BY WATER	TOTAL	PATIENTS AWAITING EVACUATION
JAPAN	1,615	19	1,634*	172
MARBO	2	1	3	0
PHILCOM (AF)	8	0	8	2
RYCOM	44	4	48	29
FEC	1,669	24	1,693	203

(*1,095 patients originated from Korea.)

Hospitalization:

The bed status as of 24 November 1950 was as follows:

	Bed Capacity		Operating		% Normal Bed	% of Operating
	Normal	Mobilization	Beds	Beds Occupd	Capacity Occupd.	Beds Occupd.
JAPAN	7,457	8,124	8,100	5,269	71	65
KOREA	2,120		5,729	1,592(3376**)	75	28
MARBO	200	200	200	60	30	30
PHILCOM(AF)	1,919	2,405	491	244	13	50
RYCOM	250	300	250	221	88	88
FEC	11,946	11,029	14,770	7,386	62	50

(**Beds occupied by POW.)

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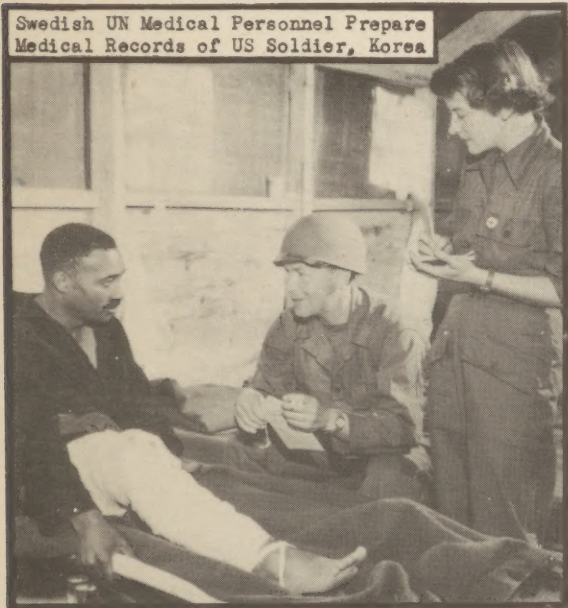
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South Korean Doctor and Nurses Sterilize Surgical Instruments, POW Hospital, Korea



Captured North Korean Nurse Cares for Wounded in POW Compound, Korea



Swedish UN Medical Personnel Prepare Medical Records of US Soldier, Korea



British Soldiers Pause for Field Mess at Taegu, Korea



Members of 60th Indian Field Amb Unit Carry Litter Casualty Near Taegu, Korea



Turkish Soldier is Prepared for Evacuation by Nurse of 81st Med Air Evac Sq, Korea

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The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Major Vincent I. Hack, Editor

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